No. 90-494

IN THE
Supreme Court of the United States
OCTOBER TERM, 1990

BLUE CROSS AND BLUE SHIELD OF ALABAMA and
TRUCK RENTALS OF ALABAMA, INC.,
Petitioners,

v.

FRED BROWN,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE AND BRIEF AMICI CURIAE FOR THE AMERICAN COUNCIL OF LIFE INSURANCE AND THE HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF THE PETITION

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The American Council of Life Insurance ("ACLI") and the Health Insurance Association of America ("HIAA") hereby move, pursuant to Rule 37.2 of the Rules of this Court, for leave to file the attached brief as *amici curiae*. Counsel for the petitioner has consented to the filing of this brief; counsel for the respondent has refused consent.

The ACLI is the largest life insurance trade association in the United States, representing the interests of 616 member life insurance companies. The ACLI's members currently hold 95 percent of the life insurance in force in legal reserve life insurance companies in the

United States. The HIAA represents the interests of 320 member companies that write over 85 percent of the health insurance written by commercial insurance companies in the United States; the HIAA's members provide health insurance coverage to approximately 95 million Americans.

The issue presented in this case—whether a court, reviewing a discretionary decision of an insurer to deny a claim for benefits under an insured employee benefit plan, must conclude that a reasonable decision is nonetheless "arbitrary and capricious" unless the insurer proves that its decision was not tainted by a conflict of interest—is vitally important to the members of the ACLI and HIAA. In 1989, at least 34 percent of health plan participants in the United States received coverage under plans funded through the purchase of group insurance policies; another 19 percent of such participants received coverage through Blue Cross-Blue Shield plans. *See Employee Benefits in Medium and Large Firms, 1989*, U.S. Department of Labor, Bureau of Labor Statistics, Bulletin 2363 (June 1990), at 39; *see also* Employee Benefit Research Institute, *EBRI Databook on Employee Benefits* (1990), at 216. Under many of these plans, the insurers have discretionary authority to process claims and interpret plan terms. Thus, the decision below, which applies a more stringent standard of review to the decisions of insurer/claims-fiduciaries of insured plans than to fiduciaries of self-insured plans, has an immediate and direct impact on the members of the ACLI and the HIAA.

Because of their nationwide constituencies, the ACLI and the HIAA are uniquely able to provide this Court with the views of the life and health insurance industries concerning the issue presented in this case and to offer additional arguments underscoring the importance of this Court's review. In other cases impacting the role that insurers play under the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.*

("ERISA"), the ACLI and the HIAA have filed *amici* briefs in this Court. *See, e.g., Firestone Tire & Rubber Co. v. Bruch*, 109 S. Ct. 948 (1989); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985). For these reasons, the Court should grant this motion for leave to file the attached brief *amici curiae* in support of the Petition.

Respectfully submitted,

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October 1990

QUESTION PRESENTED

Whether a court, reviewing a discretionary decision of an insurer to deny a claim for benefits under an insured employee benefit plan, must conclude that a reasonable decision is nonetheless "arbitrary and capricious" unless the insurer proves that its decision was not tainted by a conflict of interest.

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BRIEF AMICI CURIAE FOR THE AMERICAN COUNCIL OF LIFE INSURANCE AND THE HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF THE PETITION

INTERESTS OF THE AMICI

As stated in the motion accompanying this *amici* brief, the American Council of Life Insurance ("ACLI") is the largest life insurance trade association in the United States, representing the interests of 616 member life insurance companies. The ACLI's members currently hold 95 percent of the life insurance in force in legal reserve life insurance companies in the United States.

The Health Insurance Association of America ("HIAA") represents the interests of 320 member companies that write over 85 percent of the health insurance written by commercial insurance companies in the United States.

Defining the appropriate standard of judicial review for decisions of insurer/claims-fiduciaries of insured employee benefit plans, where those plans vest the insurer with discretionary authority, is critically important to the members of the ACLI and HIAA. In 1989, over half of the health plan participants in the United States received coverage under plans funded through the purchase of group policies from commercial insurance companies and Blue Cross-Blue Shield. *See Employee Benefits in Medium and Large Firms, 1989*, U.S. Department of Labor, Bureau of Labor Statistics, Bulletin 2363 (June 1990), at 39; *see also* Employee Benefit Research Institute, *EBRI Databook on Employee Benefits* (1990), at 216. Under many of these plans, the insurers have discretionary authority to process claims and interpret plan terms. The decision below thus directly impacts the members of the ACLI and HIAA.

This brief is filed to provide the Court with the unique perspectives of the ACLI and HIAA, based on the experiences of their broad-based constituencies, concerning the appropriate standard of review of insurer/claims-fiduciary decisions under the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA") and to offer additional arguments to underscore the importance of this Court's review.

STATEMENT

1. This case involves a decision of Blue Cross and Blue Shield of Alabama ("Blue Cross") to deny a claim for benefits under an employer-sponsored welfare benefit plan (the "Plan"). Respondent's employer, Truck Rentals of Alabama, Inc. ("Truck Rentals"), provides health insurance benefits to its employees through the purchase of insurance from Blue Cross (Pet. App. A-2). The Plan, which vests Blue Cross with claims-handling authority, provides that "whenever [Blue Cross] makes reasonable determinations which are not arbitrary and capricious in the administration of the [plan] . . . , such determinations shall be final and conclusive" (*id.* at A-6).

In September 1987, respondent entered the hospital twice for a sinus condition (Pet. App. A-2). During his first visit, respondent underwent tests and received treatment for his immediate symptoms; he entered the hospital a second time, three days after his first hospital release, to obtain surgical treatment of his sinus condition (*id.*). Respondent pre-certified neither hospital visit, even though the Plan required pre-certification for all non-emergency hospitalizations (*id.*).

Based on its interpretation of the Plan's terms, Blue Cross treated respondent's first hospitalization as a "medical emergency" and, despite his failure to pre-certify, reimbursed him for the costs associated with this hospitalization (Pet. App. A-2). Because respondent failed to pre-certify his second hospital visit, which Blue Cross considered a non-emergency, Blue Cross denied his claim for benefits associated with that hospitalization (*id.* at A-2 - A-3).

2. Respondent sued Blue Cross and Truck Rentals to compel the payment of benefits under the Plan (Pet. App. A-3). Reviewing Blue Cross' denial of benefits under an "arbitrary and capricious" standard, the United States District Court for the Northern District of Ala-

bama found that "a rational basis exists for Blue Cross' decision not to extend coverage to the second admission" and, accordingly, sustained that decision (*id.* at A-41).

3. The Eleventh Circuit reversed. The court initially concluded that the Plan gave Blue Cross discretionary decision-making authority and, therefore, compelled the application of an "arbitrary and capricious" standard of review (Pet. A-5 - A-7, *citing Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S. Ct. 948 (1989)). The court nonetheless concluded that the district court's application of a "highly deferential" standard of review was improper because of the "inherent conflict between the fiduciary role and the profit-making objective of an insurance company" (*id.* at A-12). The court thus articulated a rule to govern judicial review of discretionary decisions of insurer/claims-fiduciaries that "is shaped by th[is] . . . inherent conflict of interest" (*id.* at A-16):

> [W]hen a plan beneficiary demonstrates a substantial conflict of interest on the part of the fiduciary responsible for benefit determinations, the burden shifts to the fiduciary to prove that its interpretation of plan provisions committed to its discretion was not tainted by self-interest. That is, a wrong but apparently reasonable interpretation is arbitrary and capricious if it advances the conflicting interest of the fiduciary at the expense of the affected beneficiary or beneficiaries unless the fiduciary justifies the interpretation on the ground of its benefit to the class of all participants and beneficiaries.

Id. at A-24 - A-25. Only if the fiduciary meets this burden, the court continued, does the "focus move[] then to the familiar ways to test the fiduciary's decision against the arbitrary and capricious standard" (*id.* at A-28).

REASONS FOR GRANTING THE WRIT

I. THE FEDERAL COURTS OF APPEALS HAVE ADOPTED VARYING APPROACHES IN REVIEWING DISCRETIONARY DECISIONS OF ERISA PLAN FIDUCIARIES UNDER THE "ARBITRARY AND CAPRICIOUS" STANDARD SINCE THIS COURT'S DECISION IN *FIRESTONE TIRE & RUBBER CO. v. BRUCH*

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S. Ct. 948, 956 (1989), this Court held that a denial of a claim for benefits under an ERISA-covered plan "is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." The Court made clear in *Firestone* that application of the *de novo* standard obviated the need to "distinguish between types of plans" or to determine "whether the administrator or fiduciary is operating under a possible or actual conflict of interest." *Id.* The Court, however, indicated that these factors could still be relevant when the plan vests a fiduciary with discretion to make benefit determinations. Thus, the Court explained that "if the benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'factor[] in determining whether there is an abuse of discretion.'" *Id.*, *quoting* Restatement (Second) of Trusts § 187, Comment *d* (1959).

Since this Court's decision in *Firestone*, the federal courts of appeals have varied in their application of the "abuse of discretion" standard to decisions of fiduciaries exercising discretionary authority under a plan. Where the interests of the decision-making fiduciaries obviously do not conflict with those of participants and beneficiaries, the courts have predictably deferred to reasonable fiduciary decisions under an "abuse of discretion" or "arbitrary and capricious" standard. *See, e.g., Exbom v.*

Central States, Southeast & Southwest Areas Health & Welfare Fund, 900 F.2d 1138 (7th Cir. 1990) (court deferred to denial of health benefits by board of trustees comprised of equal number of employer and union trustees); *Jones v. Laborers Health & Welfare Trust Fund*, 906 F.2d 480 (9th Cir. 1990) (same); *Bali v. Blue Cross and Blue Shield Ass'n*, 873 F.2d 1043 (7th Cir. 1989) (court deferred to denial of employee's claim for benefits where decision-maker was neither the insurer nor the employer); *see also Jett v. Blue Cross & Blue Shield of Alabama*, 890 F.2d 1137 (11th Cir. 1989) (arbitrary and capricious standard applies to decision of insurer administrator of self-insured plan). But, where the decision-makers wear "two hats," courts have adopted varying approaches in reviewing their discretionary decisions.

On one hand, courts have deferred to the decisions of plan administrators who simultaneously serve as both employees of the plan sponsor and claims-fiduciaries. In *De Nobel v. Vitro Corp.*, 885 F.2d 1180 (4th Cir. 1989), for example, the Fourth Circuit upheld the decision of the employee-administrators to deny enhanced retirement benefits to certain participants in a defined benefit pension plan, holding that courts cannot overturn as an "abuse of discretion" benefit determinations based on a fiduciary's " 'reasonable interpretation' of disputed provisions." *Id.* at 1188 (citations omitted). In applying this deferential standard, the Fourth Circuit declined to "attribute 'presumptive bias' to the administrators—notwithstanding that they serve dual roles as company employees and pension plan fiduciaries." *Id.* at 1191; *see also Davis v. Kentucky Finance Cos. Retirement Plan*, 887 F.2d 689, 694 (6th Cir. 1989) (conflict of interest of employee-administrator is only one factor in determining whether decision was arbitrary and capricious), *cert. denied*, 110 S. Ct. 1924 (1990). Other courts, prior to this Court's decision in *Firestone*, had similarly applied this deferential "arbitrary and capricious" stand-

ard to the decisions of employer-appointed fiduciaries of employer-funded plans. *See, e.g., Van Boxel v. Journal Company Employees' Pension Trust*, 836 F.2d 1048, 1050-53 (7th Cir. 1988); *Jung v. FMC Corp.*, 755 F.2d 708, 711 (9th Cir. 1985).[1]

In contrast, the Eleventh Circuit has been unwilling to defer to the decisions of insurer representatives who similarly wear two hats. In the instant case, the court of appeals concluded that, unlike the decisions of the employee-administrators in *De Nobel*, the decisions of fiduciaries of insured plans, who serve as both representatives of the insurer and claims-handling fiduciaries, "inherently implicate the hobgoblin of self-interest" (Pet. App. A-27). It thus held that this "perpetual conflict" precludes reliance on a deferential standard of review and shifts the burden to the insurer-fiduciary to dis-

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[1] A defined benefit plan, like that at issue in *De Nobel*, provides a fixed level of pension benefits to plan participants. *See Mead Corp. v. Tilley*, 109 S. Ct. 2156, 2159 (1989). Under such plans, the employer is responsible for making whatever plan contributions are necessary to fund the benefits on an actuarially-sound basis; the employer, who assumes the risk of the plan's actuarial experience, must make up any shortfall in plan assets resulting from adverse actuarial experience. *See Nachman Corp. v. PBGC*, 446 U.S. 359, 363-64 n.5 (1980); *Blessitt v. Retirement Plan*, 848 F.2d 1164, 1177 (11th Cir. 1988) (en banc). Thus, while a fiduciary's claims decisions do not have an immediate impact on the employer-sponsor of such defined benefit plans, those decisions do financially affect the employer to the extent that claims payments exceed actuarially-anticipated amounts and require increased employer contributions. *See Van Boxel v. Journal Company Employees' Pension Trust*, 836 F.2d 1048 (7th Cir. 1988); *Lowry v. Bankers Life & Casualty Retirement Plan*, 871 F.2d 522, 525-26 n.7 (5th Cir. 1989), *cert. denied*, 110 S. Ct. 152 (1989). This arrangement has prompted at least one author to question the impartiality of decision-makers who are "'creatures' of the employer who appoints them, [who] generally employs them, and who may remove them at will" and thus "are typically not the loyal trustees for participants and beneficiaries that the common law of trusts envisions." Bruce, *Pension Claims: Rights and Obligations* (BNA 1988) 311.

prove the taint of self-interest (*id.* at A-24 - A-25). Under the Eleventh Circuit's test, therefore, courts can defer to a "wrong but apparently reasonable interpretation" under the arbitrary and capricious standard *only* if the "interested" fiduciary "justifies its interpretation on the ground of its benefit to the class of all participants and beneficiaries" (*id.*). *See also Anderson v. Blue Cross/Blue Shield of Alabama*, 907 F.2d 1072, 1076 (11th Cir. 1990) (describing *Brown* standard as similar to *de novo* review); *Newell v. Prudential Ins. Co.*, 904 F.2d 644, 651 (11th Cir. 1990) (applying *Brown* standard); *but see Pierre v. Connecticut General Life Ins. Co.*, 866 F.2d 141, 143 (5th Cir. 1989) (without addressing *Firestone*, court concluded that arbitrary and capricious standard applies when insurer is the decision-making fiduciary despite potential self-interest).[2]

The Eleventh Circuit's formulation of the "arbitrary and capricious" standard—which elevates "conflict of interest" to more than merely "a factor" in judicial review (*Firestone Tire & Rubber Co. v. Bruch*, 109 S. Ct. at 956)—thus departs markedly from the deferential review standard that the Fourth Circuit applied in *De Nobel* to "interested" decision-makers. While the decision-makers in both the instant case and *De Nobel* had, as fiduciaries, a duty of loyalty to plan participants and beneficiaries (*see* 29 U.S.C. § 1104), they both also served as employees of an interested entity. Here, the decision-makers were employees of an insurer who paid benefits out of the insurer's assets in exchange for the plan sponsor's payment of experience-rated premiums; in *De Nobel*, the decision-makers were employees of a plan sponsor who was responsible for ensuring, through plan

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[2] As the *amici* explain in Part II of this brief, it is not at all clear that such a "perpetual conflict" actually exists in cases where an insurance company both insures a plan and makes claims decisions. *See* discussion, *infra*, at 10-12. Such a conflict, if it exists at all, is quite attenuated. *Id.*

contributions, an adequate level of funds to pay benefits. While the Fourth Circuit refused to find "presumptive bias" in the actions of the "interested" decision-makers in *De Nobel* (considering bias, instead, as one factor in its review), the Eleventh Circuit here applied precisely such a presumption—it shifted the burden to the insurer/claims-fiduciary to disprove its bias and conditioned resort to traditional, multi-factored "arbitrary and capricious" review on that proof.

The decision below thus spawns confusion concerning the proper application of the "abuse of discretion" standard and undermines the concern for uniformity that motivated Congress to establish a federal fiduciary standard in ERISA. In describing the need for such a standard, Congress explained that certain plans—like insured plans—were not structured as "trusts" and, accordingly, had not been subject to trust law principles. *See* H. Rep. No. 533, 93d Cong., 1st Sess. 11-12 (1973), *reprinted in* 2 *Legislative History of the Employee Retirement Income Security Act ("Legislative History")* 2348, 2358-59 (Comm. Print 1976). Congress thus adopted a uniform, federal fiduciary standard applicable to *all* covered plans, regardless of their method of funding:

> [A] fiduciary standard embodied in Federal legislation is considered desirable because it will bring a measure of uniformity in an area where decisions under the same set of facts may differ from state to state. . . . [I]t is evident that the operations of employee benefit plans are increasingly interstate. The uniformity of decision which the Act is designed to foster will help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws.

Id. at 12, *reprinted* in 2 *Legislative History* 2359. *See also* S. Rep. No. 127, 93d Cong., 1st Sess. 35 (1973), *reprinted in* 1 *Legislative History* 587, 621 ("Because of the interstate character of employee benefit plans, the

Committee believes it is essential to provide for a uniform source of law . . . for evaluating fiduciary conduct").

The decision below plainly jeopardizes this uniformity in decision-making that Congress sought to ensure when it enacted ERISA. While this Court in *Firestone* provided needed guidance concerning the proper application of the *de novo* standard of review of fiduciary decisions, the Court had no opportunity to define the parameters of the "abuse of discretion" standard. This case presents an opportunity for the Court to do so and, at the same time, to "bring a measure of uniformity" to judicial review of discretionary decisions of plan fiduciaries. *See* H. Rep. No. 533, 93d Cong., 1st Sess. 12 (1973), *reprinted in* 2 *Legislative History* 2359.

II. THE DECISION BELOW CREATES AN UNTENABLE DISTINCTION BETWEEN INSURED AND SELF-INSURED PLANS FOR PURPOSES OF JUDICIAL REVIEW OF DISCRETIONARY DECISIONS OF PLAN FIDUCIARIES

The court below recognized that its formulation of the "arbitrary and capricious" standard of review "draw[s] a distinction between plans that are truly trusts and plans that are based solely on contracts or policies for insurance" (Pet. App. A-27), imposing on the latter plans the substantial burden of dispelling the taint of self-interest "inherent" in the actions of insurer/claims-fiduciaries. That distinction, however, misconstrues the function of insured plans and undermines their important role under ERISA.

The court of appeals' pronouncement that an insurer's "fiduciary role lies in perpetual conflict with its profit-making role as a business" (Pet. App. A-11) plainly misperceives the operation of insured plans under ERISA. ERISA makes clear that employers can fund welfare benefits for their employees "through the purchase of in-

surance . . ." (29 U.S.C. § 1002(1)); it also makes clear that its fiduciary standards apply to claims-handling fiduciaries of these insured plans, just as they apply to fiduciaries of self-insured plans (*id.*, § 1104(a); *see also* H. Rep. No. 533, 93d Cong., 1st Sess. 11-12 (1973), *reprinted in* 2 *Legislative History* 2358-59). Consistent with these provisions, therefore, employers and insurers have structured insurance arrangements that, in operation, minimize the potential for a "conflict of interest" in the decisions of insurer/claims-fiduciaries. Indeed, because of the structure of these plans, "it is not at all clear that such conflict normally exists at all" (Mandel, *Must Claims Denials Be Upheld Unless Arbitrary and Capricious—What Standard of Review Applies to Group Policies Issued to ERISA Plans?*, 19 FORUM 457, 464 (Spring 1984):

> Many group insurance policies are experience rated, have retrospective premium provisions, are excess risk, or involve some combination of the foregoing. Experience rated means that premiums increase or decrease, in large part, depending on actual claims experience. Retrospective premium provisions allow the insurer, after the year is over, to retroactively increase premiums (up to specified levels) to make up any losses. Excess risk policies involve employer liability until certain 'trigger points' are reached, with insurer liability applying to claims processed after that point is reached. *All of these arrangements can readily lead to situations where an insurer has no direct financial interest in whether it pay[s] or denies a claim, but really functions more as a claim administrator and means for regulating cash flow.*

Id., 464 n.43 (emphasis added).

The premise for the court of appeals' application of essentially *de novo* review to an insurer/claims-fiduciary's discretionary decisions—that the insurer operates with an "inherent" or "perpetual" conflict of interest—is thus fundamentally unsound. Payments of claims under insured plans do not, as the court below suggests, result

in an unrecoverable, dollar-for-dollar depletion of the insurer's own assets. To the contrary, the insurer/claims-fiduciary pays these claims under a contract that is experience-rated, so that the insurer may increase or decrease employer premiums to account for actual claims experience. The risk that the insurer/claims-fiduciary will deny claims arbitrarily due to an inherent bias is, accordingly, likely to be no greater—and perhaps even less—than the risk that an employer-fiduciary would arbitrarily deny claims under a self-funded plan. *Cf. Van Boxel v. Journal Company Employees Pension Trust*, 836 F.2d 1048, 1051 (7th Cir. 1988) (risk that company-appointed trustees would act disloyally to participants is usually minimal).[3] While that risk is, of course, a factor in evaluating the insurer/claims-fiduciary's decision under the "abuse of discretion" standard (*see Firestone Tire & Rubber Co. v. Bruch*, 109 S. Ct. at 956), it is not the only—much less the determining—factor in reviewing such a decision. *See* Restatement (Second) of Trusts, § 187, Comment *d* (1959) (reciting factors).

The court of appeals' decision to subject insurer/claims-fiduciaries to such stringent judicial oversight, moreover, defeats the expectations of parties who contractually agree that the fiduciary's "reasonable" decisions are final and binding. In *Firestone*, this Court recognized that "a concern for impartial decisionmaking . . . [does not] foreclose[] parties from agreeing upon a narrow[] standard of review." 109 S. Ct. at 956. Employers who do so through unequivocal plan language, delegating binding claims-handling authority to the insurer, thus expect the benefit of their bargain. They expect the insurer to fulfill its fiduciary and contractual duty to engage in "reason-

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[3] Insurance companies, moreover, face substantial marketplace disincentives to deny valid claims arbitrarily. An arbitrary claims-handling record inevitably leads to disgruntled participants and, as a result, to disgruntled plan sponsors. To the extent that a particular insurer thus fails to satisfy these plan sponsors, they will simply take their business elsewhere.

able" decision-making and, through appropriate process, to issue determinations that, if reasonable, are final and binding. They should not have to expect that, just because they chose to fund their plans "through the purchase of insurance" (29 U.S.C. § 1002(1)), the contracting insurer will repeatedly have to litigate in the courts whether its reasonable determinations are nonetheless "arbitrary and capricious"—a scenario that can only mean increased administrative costs to the insurer, increased premiums for the employer, and added burdens on the courts. *See Hoiland v. Burlington Industries, Inc.*, 772 F.2d 1140, 1148 (4th Cir. 1985) (arbitrary and capricious standard "ensure[s] that primary responsibility rests with administrators 'whose experience is daily and continual, not with judges whose exposure is episodic and occasional' ") (citation omitted), *aff'd mem. sub nom., Brooks v. Burlington Industries, Inc.*, 477 U.S. 901 (1986).

The decision below, therefore, will inevitably burden the creation and maintenance of insured plans. Indeed, the court below noted that "one reason for limiting the deference when a fiduciary suffers a conflict of interest is *to discourage arrangements where a conflict arises*" (Pet. App. A-21; emphasis added)—in the court's view, where an insurer both insures the plan and processes claims. But discouraging employers who cannot afford to self-insure from providing employee benefits through the only feasible means available to them—through the purchase of insurance—threatens the security of thousands of beneficiaries who depend on employer-sponsored insurance. That threat is substantial. In 1989, at least 34 percent of health plan participants in the United States received coverage under commercially-insured plans; an additional 19 percent of these participants received coverage under Blue Cross-Blue Shield plans. *See Employee Benefits in Medium and Large Firms, 1989*, U.S. Department of Labor, Bureau of Labor Statistics, Bulletin 2363 (June 1990), at 39. This means that, in

1989, *over half* of this country's health plan participants depended on insurance arrangements for their benefits. *Id.*

Only this Court can authoritatively define the parameters of the "abuse of discretion" standard—as it applies to both insured and self-insured plans—and alleviate the disparate burden that the decision below places on the former plans. The question is a relatively simple one. It is one that is oft-recurring and thus adds to the volume of litigation in the lower courts. It is a clear example of the sort of case where this Court's review will contribute substantially both to the uniformity sought by Congress and to reducing the workload of the federal courts. The Court should, therefore, grant review.

CONCLUSION

The petition for certiorari should be granted.

Respectfully submitted,

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